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A.I.M. International Inc. Symptom Checklist

Please place a check mark under the ranking that BEST describes you for each statement.

Name:_____ Date: ____/_____/_____ __
(mm/dd/yyyy)

Statement	Never	Rarely	Occasionally	Frequently	Always
Hyper- vigilance (being on guard at all times)					
Intrusive imagery or flashbacks					
Extreme sensitivity to light and sound					
Hyperactivity					
Exaggerated emotional and startle responses					
Nightmares and night terrors					
Abrupt mood swings					
Reduced ability to deal with stress					
Difficulty falling or staying asleep					
Panic attacks or anxiety					
Difficulty concentrating					
Avoiding certain places or circumstances					
Attraction to dangerous situations					
Frequent crying					
Exaggerated or diminished sexual activity					
Inability to love, nurture or bond with others					
Fear of dying or having a shortened life					
Fear of going crazy					
Inability to make commitments					
Chronic fatigue or very low physical energy					
Headaches					
Neck and back problems					
Asthma					
Digestive problems, colitis, spastic colon					
Depression, feeling of impending doom					
Feelings of detachment, alienation & isolation					
Need for alcohol or drugs to relax					
“Spaciness” or mental blankness					
Reduced ability to formulate plans					
Feelings of helplessness					
Freezing or immobility response to danger					